FOR OHF USE

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0035618

Facility Name: BRYN MAWR CARE, INC.

Address: 5547 NORTH KENMORE (Number) CHICAGO (City) 60640 (Zip Code)

County: COOK

Telephone Number: (773) 561-7040 **Fax #** (773) 561-7543

IDPA ID Number: 36-3654908-001

Date of Initial License for Current Owners: 08/01/89

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve N. Lavenda **Telephone Number:** (847) 236-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) SEE ACCOUNTANT'S REPORT ATTACHED (Date)

(Print Name and Title) CARY C. BUXBAUM, C.P.A.

(Firm Name & Address) FROST, RUTTENBERG & ROTHBLATT, P.C.
111 Pfingsten Rd. , Suite 300, Deerfield, Il 60015

(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number BRYN MAWR CARE, INC. # 0035618 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	174	Intermediate (ICF)	174	63,684	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	174	TOTALS	174	63,684	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	0				8
9	SNF/PED					9
10	ICF	59,283	887		60,170	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	59,283	887		60,170	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.48%

D. How many bed-hold days during this year were paid by Public Aid?
1,955 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 08/01/89

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 08/01/89 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number BRYN MAWR CARE, INC. # 0035618 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	125,484	16,518	30,593	172,595		172,595	(18,394)	154,201			1
2	Food Purchase		195,830		195,830	(12,938)	182,892	(29)	182,863			2
3	Housekeeping	97,853	13,038		110,891		110,891	504	111,395			3
4	Laundry		13,234		13,234		13,234		13,234			4
5	Heat and Other Utilities			83,422	83,422		83,422	1,944	85,366			5
6	Maintenance	38,016	5,451	98,834	142,301		142,301	(36,854)	105,447			6
7	Other (specify):*							5,489	5,489			7
8	**TOTAL General Services**	261,353	244,071	212,849	718,273	(12,938)	705,335	(47,340)	657,995			8
	B. Health Care and Programs											
9	Medical Director			3,600	3,600		3,600		3,600			9
10	Nursing and Medical Records	689,794	15,682	94,513	799,989		799,989	(17,590)	782,399			10
10a	Therapy			15,456	15,456		15,456	(4,969)	10,487			10a
11	Activities	95,565	8,055	2,092	105,712		105,712		105,712			11
12	Social Services	173,060			173,060		173,060		173,060			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*							4,624	4,624			15
16	**TOTAL Health Care and Programs**	958,419	23,737	115,661	1,097,817		1,097,817	(17,935)	1,079,882			16
	C. General Administration											
17	Administrative	75,788		352,331	428,119		428,119	(248,076)	180,043			17
18	Directors Fees											18
19	Professional Services			151,745	151,745	(4,533)	147,212	(88,891)	58,321			19
20	Dues, Fees, Subscriptions & Promotions			22,411	22,411		22,411	(1,142)	21,269			20
21	Clerical & General Office Expenses	96,373	17,651	59,113	173,137		173,137	12,676	185,813			21
22	Employee Benefits & Payroll Taxes			217,225	217,225	12,938	230,163		230,163			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,732	1,732		1,732	644	2,376			24
25	Other Admin. Staff Transportation			1,708	1,708		1,708	2,858	4,566			25
26	Insurance-Prop.Liab.Malpractice			50,614	50,614		50,614	967	51,581			26
27	Other (specify):*							21,596	21,596			27
28	**TOTAL General Administration**	172,161	17,651	856,879	1,046,691	8,405	1,055,096	(299,368)	755,728			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,391,933	285,459	1,185,389	2,862,781	(4,533)	2,858,248	(364,643)	2,493,605			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

BRYN MAWR CARE, INC.
0035618
COST REPORT RECLASSIFICATIONS
01/01/00
12/31/00

SCHEDULE V LINE #			
22	EMPLOYEE BENEFITS	12,938	
2	FOOD		12,938

To reclass cost of employee meals from raw food to employee benefits

33	REAL ESTATE TAX	4,533	
19	PROFESSIONAL FEES		4,533

To reclass cost of appealing real estate taxes

Facility Name & ID Number BRYN MAWR CARE, INC. #0035618 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			82,586	82,586		82,586	42,026	124,612			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,371	1,371		1,371	390,877	392,248			32
33	Real Estate Taxes			100,701	100,701	4,533	105,234	3,975	109,209			33
34	Rent-Facility & Grounds			575,880	575,880		575,880	(575,880)				34
35	Rent-Equipment & Vehicles			8,746	8,746		8,746	9,507	18,253			35
36	Other (specify):*							8,548	8,548			36
37	**TOTAL Ownership**			769,284	769,284	4,533	773,817	(120,947)	652,870			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			95,526	95,526		95,526		95,526			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			95,526	95,526		95,526		95,526			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,391,933	285,459	2,050,199	3,727,591		3,727,591	(485,590)	3,242,001			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number BRYN MAWR CARE, INC. # 0035618 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(6,447)	30		9
10	Interest and Other Investment Income	(49,588)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(29)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(10,006)	21		24
25	Fund Raising, Advertising and Promotional	(2,203)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(21,564)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(37,194)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (127,031)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(358,559)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (358,559)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (485,590)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

BRYN MAWR CARE, INC.

ID# 0035618

Report Period Beginning: 01/01/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Deferred Maintenance	$	6	1
2	Political Contributions - COPE	(261)	20	2
3	Capitalized R&M	(20,366)	6	3
4	Jury Duty	(34)	10	4
5	Misc Income - Copying	(50)	21	5
6	Non allowable Mkt Seminar	(30)	24	6
7	Non allowable Legal fees	(16,453)	19	7
8				8
9				9
10				10
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82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	Total	(37,194)		90

STATE OF ILLINOIS — Summary A

Facility Name & ID Number BRYN MAWR CARE, INC. # 0035618 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary					(18,394)							(18,394)	1
2	Food Purchase	(29)											(29)	2
3	Housekeeping			504									504	3
4	Laundry													4
5	Heat and Other Utilities			680	1,264								1,944	5
6	Maintenance	(20,366)		420	(9,704)	(7,204)							(36,854)	6
7	Other (specify):*				678	4,811							5,489	7
8	**TOTAL General Services**	(20,395)		1,604	(7,762)	(20,787)							(47,340)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(34)			(17,556)								(17,590)	10
10a	Therapy					(4,969)							(4,969)	10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*				2,859	1,765							4,624	15
16	**TOTAL Health Care and Programs**	(34)			(14,697)	(3,204)							(17,935)	16
	C. General Administration													
17	Administrative			11,765	(54,330)	(191,713)		(13,798)					(248,076)	17
18	Directors Fees													18
19	Professional Services	(16,453)		(71,135)	(12,027)	10,634		90					(88,891)	19
20	Fees, Subscriptions & Promotions	(2,464)		303	960			59					(1,142)	20
21	Clerical & General Office Expenses	(31,620)		39,066	5,100			130					12,676	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(30)		154	520								644	24
25	Other Admin. Staff Transportation			535	2,323								2,858	25
26	Insurance-Prop.Liab.Malpractice			343	512			112					967	26
27	Other (specify):*			6,137	4,284	10,721		454					21,596	27
28	**TOTAL General Administration**	(50,567)		(12,832)	(52,658)	(170,358)		(12,953)					(299,368)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(70,996)		(11,228)	(75,117)	(194,349)		(12,953)					(364,643)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BRYN MAWR CARE, INC. # 0035618 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(6,447)	41,189	2,507	4,777								42,026	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(49,588)	436,573	978	2,830			84					390,877	32
33	Real Estate Taxes			1,266	2,709								3,975	33
34	Rent-Facility & Grounds		(575,880)										(575,880)	34
35	Rent-Equipment & Vehicles			2,164	5,784			1,559					9,507	35
36	Other (specify):*		8,548										8,548	36
37	**TOTAL Ownership**	(56,035)	(89,570)	6,915	16,100			1,643					(120,947)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**													44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(127,031)	(89,570)	(4,313)	(59,017)	(194,349)		(11,310)					(485,590)	45

Facility Name & ID Number BRYN MAWR CARE, INC. # 0035618 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Scheduled Attached		See Scheduled Attached		See Scheduled Attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 575,880	Bryn Mawr Care LLC	100.00%	$	$ (575,880)	1
2	V	32	Interest Income	216	Bryn Mawr Care LLC	100.00%		(216)	2
3	V	32	Interest Expense		Bryn Mawr Care LLC	100.00%	436,789	436,789	3
4	V	30	Depreciation		Bryn Mawr Care LLC	100.00%	41,189	41,189	4
5	V	36	Amortization		Bryn Mawr Care LLC	100.00%	8,548	8,548	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 576,096			$ 486,526	$ * (89,570)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRYN MAWR CARE, INC. # 0035618 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	HOUSEKEEPING	$	PREFERRED BOOKKEEPING	100.00%	$ 504	$ 504	15
16	V	5	UTILITIES		PREFERRED BOOKKEEPING	100.00%	680	680	16
17	V	6	REPAIRS AND MAINT.		PREFERRED BOOKKEEPING	100.00%	420	420	17
18	V	17	ADMIN. FINANCIAL SAL.		PREFERRED BOOKKEEPING	100.00%	11,765	11,765	18
19	V	19	PROFESSIONAL FEES		PREFERRED BOOKKEEPING	100.00%	1,565	1,565	19
20	V	20	DUES,SUBSCRIPTIONS		PREFERRED BOOKKEEPING	100.00%	303	303	20
21	V	21	CLERICAL		PREFERRED BOOKKEEPING	100.00%	39,066	39,066	21
22	V	24	SEMINARS		PREFERRED BOOKKEEPING	100.00%	154	154	22
23	V	25	ADMIN. STAFF TRAVEL		PREFERRED BOOKKEEPING	100.00%	535	535	23
24	V	26	INSURANCE		PREFERRED BOOKKEEPING	100.00%	343	343	24
25	V	27	EMPLOYEE BENEFITS		PREFERRED BOOKKEEPING	100.00%	6,137	6,137	25
26	V	30	DEPRECIATION		PREFERRED BOOKKEEPING	100.00%	2,507	2,507	26
27	V	32	INTEREST		PREFERRED BOOKKEEPING	100.00%	978	978	27
28	V	33	REAL ESTATE TAXES		PREFERRED BOOKKEEPING	100.00%	1,266	1,266	28
29	V	35	EQUIPMENT RENTAL		PREFERRED BOOKKEEPING	100.00%	2,164	2,164	29
30	V								30
31	V								31
32	V	19	ACCOUNT./BOOKKEEPING	72,700	PREFERRED BOOKKEEPING	100.00%		(72,700)	32
33	V	19	COMPUTER	4,176	PREFERRED BOOKKEEPING	100.00%	4,176		33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 76,876			$ 72,563	$ * (4,313)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRYN MAWR CARE, INC. # 0035618 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	S.I.R. MANAGEMENT, INC.	100.00%	$ 1,264	$ 1,264	15
16	V	6	REPAIRS AND MAINT.	15,660	S.I.R. MANAGEMENT, INC.	100.00%	5,956	(9,704)	16
17	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	678	678	17
18	V	10	NURSING	34,452	S.I.R. MANAGEMENT, INC.	100.00%	16,896	(17,556)	18
19	V	15	EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	2,859	2,859	19
20	V	17	ADMINISTRATIVE	61,068	S.I.R. MANAGEMENT, INC.	100.00%	6,738	(54,330)	20
21	V	19	PROFESSIONAL FEES	14,100	S.I.R. MANAGEMENT, INC.	100.00%	2,073	(12,027)	21
22	V	20	FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	960	960	22
23	V	21	CLERICAL & GENERAL	17,748	S.I.R. MANAGEMENT, INC.	100.00%	22,848	5,100	23
24	V	24	EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	520	520	24
25	V	25	OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	2,323	2,323	25
26	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	512	512	26
27	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	4,284	4,284	27
28	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	4,777	4,777	28
29	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	2,830	2,830	29
30	V	33	REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	2,709	2,709	30
31	V	35	EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	5,784	5,784	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 143,028			$ 84,011	$ * (59,017)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRYN MAWR CARE, INC. # 0035618 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY SALARIES	$ 17,748	S.I.R. MANAGEMENT, INC.	100.00%	$ 4,878	$ (12,870)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	821	821	16
17	V	17	ADMIN./LEGAL SALARIES	269,538	S.I.R. MANAGEMENT, INC.	100.00%	77,825	(191,713)	17
18	V	19	FINANCIAL CONSULTANT		S.I.R. MANAGEMENT, INC.	100.00%	10,634	10,634	18
19	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	10,721	10,721	19
20	V								20
21	V								21
22	V	10A	SPECIAL REHAB	15,456	S.I.R. MANAGEMENT, INC.	100.00%	10,487	(4,969)	22
23	V	15	EMP. BEN.-HEALTH CARE & PROG.		S.I.R. MANAGEMENT, INC.	100.00%	1,765	1,765	23
24	V								24
25	V								25
26	V	6	REPAIRS AND MAINT.	23,696	S.I.R. MANAGEMENT, INC.	100.00%	16,492	(7,204)	26
27	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	2,871	2,871	27
28	V								28
29	V								29
30	V	1	DIETICIAN SALARIES	12,000	S.I.R. MANAGEMENT, INC.	100.00%	6,476	(5,524)	30
31	V	7	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	1,119	1,119	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 338,438			$ 144,089	$ * (194,349)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRYN MAWR CARE, INC. # 0035618 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	EMPLOYEE HEALTH INS.	$	CCS EMPLOYEE BENEFIT GROUP	100.00%	$ 69,796	$ 69,796	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INS.	69,796	CCS EMPLOYEE BENEFIT GROUP	100.00%		(69,796)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 69,796			$ 69,796	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRYN MAWR CARE, INC. # 0035618 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	$	ECM OWNERS COUNCIL	100.00%	$ 90	$ 90	15
16	V	20	DUES, FEES & SUBSCRIPTIONS		ECM OWNERS COUNCIL	100.00%	59	59	16
17	V	21	CLERICAL		ECM OWNERS COUNCIL	100.00%	130	130	17
18	V	26	INSURANCE		ECM OWNERS COUNCIL	100.00%	112	112	18
19	V	32	INTEREST		ECM OWNERS COUNCIL	100.00%	84	84	19
20	V	35	VEHICLE RENTAL		ECM OWNERS COUNCIL	100.00%	1,559	1,559	20
21	V	17	MANAGEMENT FEES	21,600	ECM OWNERS COUNCIL	100.00%		(21,600)	21
22	V								22
23	V	17	ADMIN. SAL. - M. GIANNINI		ECM OWNERS COUNCIL	100.00%	7,802	7,802	23
24	V	27	EMP. BEN. - M. GIANNINI		ECM OWNERS COUNCIL	100.00%	454	454	24
25	V	17	ADMIN. SALARY		ECM OWNERS COUNCIL	100.00%	0		25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 21,600			$ 10,290	$ * (11,310)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRYN MAWR CARE, INC. # 0035618 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRYN MAWR CARE, INC. # 0035618 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRYN MAWR CARE, INC. # 0035618 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRYN MAWR CARE, INC. # 0035618 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRYN MAWR CARE, INC. # 0035618 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Eric Rothner	Stockholder	Administrative	46.55%	See Attached	0.59	0.82%	Alloc Salary	$ 6,263	17-7	1
2	Bryan Barrish	Stockholder	Administrative	27.01%	See Attached	4.21	8.42%	Alloc Salary	24,597	17-7	2
3	Mike Giannini	Stockholder	Administrative	1.44%	See Attached	3.74	7.48%	Alloc Salary	22,500	17-7	3
4	Arturo Romniquit	Relative	Clerical		See Attached	3.31	8.28%	Alloc Salary	1,809	21-7	4
5	Nenita Guzman	Relative	Dietary		See Attached	5.15	9.36%	Alloc Salary	4,878	1-7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 60,047		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number BRYN MAWR CARE, INC. # 0035618 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number (
Fax Number (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number BRYN MAWR CARE, INC. # 0035618 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: PREFERRED BOOKEEPING SERVICES
Street Address: 4100 WEST PRATT AVE.
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 674-5200
Fax Number: (847) 674-5267

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	BOOK./ACCNT.INCOME	878,492	11	$ 6,088	$	72,700	$ 504	1
2	5	UTILITIES	BOOK./ACCNT.INCOME	878,492	11	8,220		72,700	680	2
3	6	REPAIRS AND MAINT.	BOOK./ACCNT.INCOME	878,492	11	5,069		72,700	420	3
4	17	ADMIN. FINANCIAL SAL.	BOOK./ACCNT.INCOME	878,492	11	142,165	142,165	72,700	11,765	4
5	19	PROFESSIONAL FEES	BOOK./ACCNT.INCOME	878,492	11	18,910		72,700	1,565	5
6	20	DUES,SUBSCRIPTIONS	BOOK./ACCNT.INCOME	878,492	11	3,657		72,700	303	6
7	21	CLERICAL	BOOK./ACCNT.INCOME	878,492	11	472,061	403,426	72,700	39,066	7
8	24	SEMINARS	BOOK./ACCNT.INCOME	878,492	11	1,858		72,700	154	8
9	25	ADMIN. STAFF TRAVEL	BOOK./ACCNT.INCOME	878,492	11	6,465		72,700	535	9
10	26	INSURANCE	BOOK./ACCNT.INCOME	878,492	11	4,146		72,700	343	10
11	27	EMPLOYEE BENEFITS	BOOK./ACCNT.INCOME	878,492	11	74,163		72,700	6,137	11
12	30	DEPRECIATION	BOOK./ACCNT.INCOME	878,492	11	30,298		72,700	2,507	12
13	32	INTEREST	BOOK./ACCNT.INCOME	878,492	11	11,823		72,700	978	13
14	33	REAL ESTATE TAXES	BOOK./ACCNT.INCOME	878,492	11	15,297		72,700	1,266	14
15	35	EQUIPMENT RENTAL	BOOK./ACCNT.INCOME	878,492	11	26,147		72,700	2,164	15
16										16
17										17
18										18
19	19	COMPUTER	DIRECT ALLOCATION						4,176	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 826,367	$ 545,591		$ 72,563	25

Facility Name & ID Number BRYN MAWR CARE, INC. # 0035618 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: S.I.R. MANAGEMENT, INC.
Street Address: 6840 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 675 -7979
Fax Number: (847) 675 -0555

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	642,911	10	$ 13,508	$	60,170	$ 1,264	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	642,911	10	63,644	42,834	60,170	5,956	2
3	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	642,911	10	7,250		60,170	678	3
4	10	NURSING	PATIENT DAYS	642,911	10	180,529	180,529	60,170	16,896	4
5	15	EMP. BEN.-H.C.	PATIENT DAYS	642,911	10	30,553		60,170	2,859	5
6	17	ADMINISTRATIVE	PATIENT DAYS	642,911	10	71,994	71,994	60,170	6,738	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	642,911	10	22,153		60,170	2,073	7
8	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	642,911	10	10,256		60,170	960	8
9	21	CLERICAL & GENERAL	PATIENT DAYS	642,911	10	244,124	177,193	60,170	22,848	9
10	24	EDUCATION & SEMINAR	PATIENT DAYS	642,911	10	5,556		60,170	520	10
11	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	642,911	10	24,821		60,170	2,323	11
12	26	INSURANCE	PATIENT DAYS	642,911	10	5,468		60,170	512	12
13	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	642,911	10	45,778		60,170	4,284	13
14	30	DEPRECIATION	PATIENT DAYS	642,911	10	51,045		60,170	4,777	14
15	32	INTEREST	PATIENT DAYS	642,911	10	30,234		60,170	2,830	15
16	33	REAL ESTATE TAXES	PATIENT DAYS	642,911	10	28,948		60,170	2,709	16
17	35	EQUIPMENT RENTAL	PATIENT DAYS	642,911	10	61,803		60,170	5,784	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 897,664	$ 472,550		$ 84,011	25

Facility Name & ID Number BRYN MAWR CARE, INC. # 0035618 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: S.I.R. MANAGEMENT, INC.
Street Address: 6840 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 675 -7979
Fax Number: (847) 675 -0555

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY SALARIES	PATIENT DAYS	642,911	10	$ 52,122	$ 52,122	60,170	$ 4,878	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	642,911	10	8,770		60,170	821	2
3	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	642,911	10	831,558	831,558	60,170	77,825	3
4	19	FINANCIAL CONSULTANT	PATIENT DAYS	642,911	10	113,620		60,170	10,634	4
5	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	642,911	10	$ 114,558	$	60,170	$ 10,721	5
6										6
7										7
8	10A	SPECIAL REHAB	SPECIAL REHAB INC.	82,944	4	56,277	56,277	15,456	10,487	8
9	15	EMP. BEN.-HEALTH CARE & P	SPECIAL REHAB INC.	82,944	4	$ 9,470	$	15,456	$ 1,765	9
10										10
11										11
12	6	REPAIRS AND MAINT.	MAINTENANCE INC.	237,604	10	165,366	165,366	23,696	16,492	12
13	7	EMP. BEN.-GEN. SERV.	MAINTENANCE INC.	237,604	10	$ 28,790	$	23,696	$ 2,871	13
14										14
15										15
16	1	DIETICIAN SALARIES	DIETICIAN SERVICE INC.	125,400	10	67,672	67,672	12,000	6,476	16
17	7	EMP. BEN.-GEN. ADMIN.	DIETICIAN SERVICE INC.	125,400	10	11,698		12,000	1,119	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,459,901	$ 1,172,995		$ 144,089	25

Facility Name & ID Number BRYN MAWR CARE, INC. # 0035618 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CCS EMPLOYEE BENEFITS GROUP, INC.
Street Address: 4101 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 674-1180
Fax Number: (847) 673-7741

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INS.	DIRECT ALLOCATION			$	$		$ 69,796	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 69,796	25

Facility Name & ID Number BRYN MAWR CARE, INC. # 0035618 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: ECM OWNERS COUNCIL
Street Address: 6840 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 676-2026
Fax Number: (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	ECMOC MGMNT FEE INC.	96,000	9	$ 400	$	21,600	$ 90	1
2	20	DUES, FEES & SUBSCRIPTION	ECMOC MGMNT FEE INC.	96,000	9	264		21,600	59	2
3	21	CLERICAL	ECMOC MGMNT FEE INC.	96,000	9	579		21,600	130	3
4	26	INSURANCE	ECMOC MGMNT FEE INC.	96,000	9	496		21,600	112	4
5	32	INTEREST	ECMOC MGMNT FEE INC.	96,000	9	374		21,600	84	5
6	35	VEHICLE RENTAL	ECMOC MGMNT FEE INC.	96,000	9	6,931		21,600	1,559	6
7										7
8										8
9	17	ADMIN. SAL. - M. GIANNINI	ADMIN. HOURS	39	9	81,858	81,858	4	7,802	9
10	27	EMP. BEN. - M. GIANNINI	ADMIN. HOURS	39	9	4,762		4	454	10
11	17	ADMIN. SALARY	DIRECT ALLOCATION							11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 95,664	$ 81,858		$ 10,290	25

Facility Name & ID Number BRYN MAWR CARE, INC. # 0035618 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number BRYN MAWR CARE, INC. # 0035618 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number BRYN MAWR CARE, INC. # 0035618 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number BRYN MAWR CARE, INC. # 0035618 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number BRYN MAWR CARE, INC. # 0035618 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Nomura		X	Mortgage	$42,679.00	3/1/96	$ 5,217,000	$ 4,902,898	3/1/08	8.6900	$ 436,790	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$42,679.00		$ 5,217,000	$ 4,902,898			$ 436,790	9
	B. Non-Facility Related*											
10	Supplemental Schedule										3,676	10
11	Insurance Financing		X	Insurance Premiums			41,007				1,371	11
12	Interest Income	X									(49,588)	12
13												13
14	TOTAL Non-Facility Related						$ 41,007	$			$ (44,541)	14
15	TOTALS (line 9+line14)						$ 5,258,007	$ 4,902,898			$ 392,249	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number BRYN MAWR CARE, INC. # 0035618 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	Alloc. ECM Owners Council	X					$	$			$ 84	1
2	Alloc. Prefferred Bkpg	X									978	2
3	Interest Income -Bldg	X									(216)	3
4	Alloc. SIR Management	X									2,830	4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ 3,676	21

Facility Name & ID Number BRYN MAWR CARE, INC. # 0035618 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	116,700	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	110,976	2
3. Under or (over) accrual (line 2 minus line 1).	$	(5,724)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	110,400	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$	4,533	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ 5,740 For 19 97 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	109,209	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	120,164	8
	1996	123,120	9
	1997	111,190	10
	1998	113,164	11
	1999	107,001	12

2000 ACCRUAL= 1999 BILL 107001 * 1.032 AND ROUNDED

ALLOCATION FROM PREFFERRED BKPG $1,266

ALLOCATION FROM SIR MANAGEMENT $2,709

1997 Refund not offset since it applies to year that was not used to se to set a R/E Tax Rate

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number BRYN MAWR CARE, INC. # 0035618 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 39,120 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 6

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1			1989	$ 63,070	1
2					2
3	TOTALS			$ 63,070	3

Facility Name & ID Number BRYN MAWR CARE, INC. # 0035618 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	174		1989		$ 1,443,623	$ 41,189	35	$ 41,246	$ 57	$ 470,892	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1989	3,323	105	20	133	28	1,496	9
10	Various			1990	21,607	686	20	1,081	395	11,380	10
11	Various			1991	99,075	3,146	20	4,955	1,809	46,388	11
12	Various			1992	37,297	328	20	1,865	1,537	16,375	12
13	Various			1993	18,516	476	20	853	377	8,094	13
14	Various			1994	33,458	429	20	2,429	2,000	15,494	14
15	Various			1995	64,419	1,650	20	3,497	1,847	19,407	15
16	SERVICE A/C CIRCUITS			1996	1,201	31	20	60	29	265	16
17	PIPE WORK			1996	4,500	115	20	225	110	1,013	17
18	PAVING PARKING LOT			1996	3,140	217	20	157	(60)	654	18
19	SOIL REMEDIATION			1996	64,384		20	3,219	3,219	14,754	19
20	BLINDS			1996	8,494	979	20	425	(554)	1,913	20
21	PAINTING &DECORATING			1996	34,547		20	1,727	1,727	7,772	21
22	BATHTUB REGLAZING			1996	3,245		20	162	162	729	22
23	CARPETING			1996	3,569	411	20	178	(233)	801	23
24											24
25	PAGE 12-1 REP TOTALS				72,982	3,018		2,836	(182)	16,074	25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34	PAGE 12B TOTALS				183,750	21,685		7,932	(13,753)	9,775	34
35	PAGE 12A TOTALS				339,928	12,730		16,592	3,862	51,552	35
36	TOTAL (lines 4 thru 35)				$ 2,441,058	$ 87,195		$ 89,572	$ 2,377	$ 694,828	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRYN MAWR CARE, INC. # 0035618 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	OUTDOOR STORAGE SHED			1996	7,200	185	20	360	175	1,560	9
10	SEWER WORK			1997	1,800		20	90	90	338	10
11	PLUMBING			1997	1,506		20	75	75	238	11
12	BATHTUB RENOVATIONS			1997	17,662	453	20	883	430	3,017	12
13	BATHTUB RENOVATIONS			1997	5,470	140	20	274	134	891	13
14	WATER HEATER			1997	8,500	979	20	425	(554)	1,310	14
15	STEAM HEAT BOILER			1997			20				15
16	TUCKPOINTING			1997	1,150		20	58	58	218	16
17	TUCKPOINTING			1997	6,600	169	20	330	161	1,018	17
18	FLOOR TILE			1997	7,191	828	20	719	(109)	2,457	18
19	ELEVATOR IMPROV			1997	50,460	1,294	20	2,523	1,229	9,041	19
20	WINDOW DRESSING			1997	10,851		20	543	543	1,991	20
21	STEAM HEAT BOILER			1997	21,409	2,466	20	1,070	(1,396)	4,013	21
22	BATHTUB RENOVATIONS			1997	15,316	393	20		(393)		22
23	BATHROOM VANITY			1997	4,257	490	20	213	(277)	746	23
24	HOT WATER TANK			1997	2,150	248	20	108	(140)	360	24
25	SEWER WORK			1997	650		20	33	33	118	25
26	LANDSCAPE			1997	26,716	685	20	1,336	651	4,453	26
27	AIR PURIFICATION			1997	3,231	372	20	162	(210)	608	27
28	ELEVATOR			1998	33,640	863	20	1,682	819	4,345	28
29	FIRE ALARM			1998	74,900	1,921	20	3,745	1,824	9,675	29
30	FLOORING			1998	7,789	200	20	389	189	1,167	30
31	BATHROOM REMODEL			1998	4,252	109	20	213	104	621	31
32	PAINTING			1998	5,200		20	260	260	715	32
33	OUTDOOR LIGHTING			1998	4,300	110	20	215	105	520	33
34	WOLF ROOFING			1998	15,500	397	20	775	378	1,808	34
35	BOILER CONTROLLER			1998	2,228	428	20	111	(317)	324	35
36	TOTAL (lines 4 thru 35)				$ 339,928	$ 12,730		$ 16,592	$ 3,862	$ 51,552	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRYN MAWR CARE, INC. # 0035618 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	TUCKPOINTING			1998	2,600		20	130	130	303	9
10	WOLF ROOFING			1998	18,000	462	20	900	438	2,025	10
11	DOORS			1998	2,079		20	104	104	277	11
12	DOORS			1998	1,076	207	20	54	(153)	140	12
13	SIR MGMT ALLOC			1999	9,735	250	20	487	237	649	13
14	FIRE DOORS (22)			1999	29,826		20	1,491	1,491	1,615	14
15	WINDOWS			2000	99,727	19,946	20	4,571	(15,375)	4,571	15
16	WATER HEATER			2000	4,100	820	20	34	(786)	34	16
17	A/C WORK			2000	3,360		20	70	70	70	17
18	DOOR MONITORING			2000	2,199		20	35	35	35	18
19	ELECTRIC WIRING			2000	1,046		20	14	14	14	19
20	ELECTRICAL WORK			2000	5,702		20	24	24	24	20
21	ROOF			2000	4,300		20	18	18	18	21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 183,750	$ 21,685		$ 7,932	$ (13,753)	$ 9,775	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRYN MAWR CARE, INC. # 0035618 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRYN MAWR CARE, INC. # 0035618 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRYN MAWR CARE, INC. # 0035618 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
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26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRYN MAWR CARE, INC. # 0035618 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
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26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRYN MAWR CARE, INC. # 0035618 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
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26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRYN MAWR CARE, INC. # 0035618 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
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25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRYN MAWR CARE, INC. # 0035618 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
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17											17
18											18
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27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRYN MAWR CARE, INC. # 0035618 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
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15											15
16											16
17											17
18											18
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26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRYN MAWR CARE, INC. # 0035618 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1993	Alloc S.I.R.	$ 11,686	$ 371	35	$ 334	$ (37)	$ 2,504	4
5			1993	Alloc S.I.R.	25,008	794	35	715	(79)	5,359	5
6											6
7											7
8											8
	Improvement Type**										
9	Allocation From Preferred Bookkeeping			1997	14,594	550	20	730	180	2,779	9
10	Allocation From Preferred Bookkeeping			1999	116	37	20	6	(31)	9	10
11	Allocation From Preferred Bookkeeping			2000	732		20	15	15	15	11
12	Allocation From SIR Properties - Preferred Bookkpg			1999	1,481	148	20	74	(74)	111	12
13	Allocation From SIR Properties - Preferred Bookkpg			1998	708	71	20	35	(36)	88	13
14	Allocation From SIR Properties - Preferred Bookkpg			1997	44	4	20	2	(2)	10	14
15	Allocation From SIR Properties - Preferred Bookkpg			1994	111	3	20	6	3	36	15
16	Allocation From SIR Properties - Preferred Bookkpg			1993	190	10	20	9	(1)	71	16
17	Allocation From SIR Management			1993	10,741	357	20	542	185	4,233	17
18	Allocation From SIR Management			1994	34		20	3	3	21	18
19	Allocation From SIR Management			1995	245	14	20	12	(2)	66	19
20	Allocation From SIR Management			1999	1,167	77	20	58	(19)	71	20
21	Allocation From SIR Management			2000	704	77	20	24	(53)	24	21
22	Allocation From SIR Properties - SIR Management			1999	3,169	317	20	158	(159)	238	22
23	Allocation From SIR Properties - SIR Management			1998	1,514	151	20	76	(75)	189	23
24	Allocation From SIR Properties - SIR Management			1997	94	9	20	5	(4)	21	24
25	Allocation From SIR Properties - SIR Management			1994	238	6	20	12	6	77	25
26	Allocation From SIR Properties - SIR Management			1993	406	22	20	20	(2)	152	26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 72,982	$ 3,018		$ 2,836	$ (182)	$ 16,074	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRYN MAWR CARE, INC. # 0035618 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRYN MAWR CARE, INC. # 0035618 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 331,575	$ 30,846	$ 31,510	$ 664		$ 166,890	37
38	Current Year Purchases	10,322	1,285	425	(860)		425	38
39	Fully Depreciated Assets	180,838	11,733	3,105	(8,628)		180,838	39
40								40
41	TOTALS	$ 522,735	$ 43,864	$ 35,040	$ (8,824)		$ 348,153	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 3,026,863	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 131,059	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 124,612	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ (6,447)	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 1,042,981	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

BRYN MAWR CARE, INC.
0035618
RELATED COMPANY MOVABLE EQUIPMENT SCHEDULE
12/31/00

LINE 28: PRIOR YEARS

COMPANY NAME	COST	CURRENT BOOK (FED) DEPRECIATION	STRAIGHT LINE DEPRECIATION	ADJUSTMENTS	ACCUMULATED S/L DEPRECIATION
BRYN MAWR CARE, INC.	279,168	26,873	26,392	(481)	133,808
Preferred Bookkeeping	16,953	1,214	1,573	359	10,398
SIR Properties - Preferred Bookkeeping	11		1	1	8
SIR Management	35,420	2,759	3,542	783	22,658
SIR Properties - SIR Management	23		2	2	18
TOTALS	331,575	30,846	31,510	664	166,890

LINE 29: CURRENT YEAR

BRYN MAWR CARE, INC.	8,717	992	330	(662)	330
Preferred Bookkeeping	494	99	41	(58)	41
SIR Properties - Preferred Bookkeeping					
SIR Management	1,111	194	54	(140)	54
SIR Properties - SIR Management					
TOTALS	10,322	1,285	425	(860)	425

LINE 30: FULLY DEPRECIATED

BRYN MAWR CARE, INC.	180,838	11,733	3,105	(8,628)	180,838
Preferred Bookkeeping					
SIR Properties - Preferred Bookkeeping					
SIR Management					
SIR Properties - SIR Management					
TOTALS	180,838	11,733	3,105	(8,628)	180,838

TOTALS (Should Tie to Totals on Page 13)

BRYN MAWR CARE, INC.	468,723	39,598	29,827	(9,771)	314,976
Preferred Bookkeeping	17,447	1,313	1,614	301	10,439
SIR Properties - Preferred Bookkeeping	11		1	1	8
SIR Management	36,531	2,953	3,596	643	22,712
SIR Properties - SIR Management	23		2	2	18
TOTALS	522,735	43,864	35,040	(8,824)	348,153

Facility Name & ID Number BRYN MAWR CARE, INC. # 0035618 Report Period Beginning: 01/01/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 9,475 Description: SEE ATTATCHED SCHEDULE
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocation From ECM Owners Cncl.		$	$ 1,559	17
18	Alloc SIR Management			5,564	18
19	Alloc Preferred Bookkpg			1,656	19
20					20
21	TOTAL		$	$ 8,779	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number BRYN MAWR CARE, INC. # 0035618 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	N/A	hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): **SEE SUPPLEMENTAL SCHEDULE**									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SUPPLEMENTAL SCHEDULE OF MEDICAL SUPPLIES

	Special Services - Supplies (Column 6 - Other)	Amount
1	Medical Supplies	
2	Complex Medical Equip	
3	Oxygen	
4	Equipment Rental	
5		
6		
7		
8		
9		
10		

	Outside Therapies (Column 5 - Other)	Amount
1	Respiratory Therapy	
2		
3		
4		
5		
6		
7		
8		
9		
10		

STATE OF ILLINOIS

Facility Name & ID Number BRYN MAWR CARE, INC. # 0035618 Report Period Beginning: 01/01/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 44,529	$ 49,889	1
2	Cash-Patient Deposits	34,331	34,331	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	711,679	711,679	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	2,301	2,301	6
7	Other Prepaid Expenses	1,095	1,095	7
8	Accounts Receivable (owners or related parties)	346,578	346,578	8
9	Other(specify): See supplemental schedule	54,839	54,839	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,195,352	$ 1,200,712	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		207,475	13
14	Buildings, at Historical Cost		1,310,914	14
15	Leasehold Improvements, at Historical Cos	531,220	531,220	15
16	Equipment, at Historical Cost	858,038	858,038	16
17	Accumulated Depreciation (book methods)	(811,437)	(1,294,753)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule	3,625	64,526	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 581,446	$ 1,677,420	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,776,798	$ 2,878,132	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 79,425	$ 79,425	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	37,148	37,148	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	100,532	100,532	30
31	Accrued Taxes Payable (excluding real estate taxes)	8,723	8,723	31
32	Accrued Real Estate Taxes(Sch.IX-B)	110,400	110,400	32
33	Accrued Interest Payable		24,854	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	25,650	25,650	35
	Other Current Liabilities(specify):			
36	See supplemental schedule	102,611	102,611	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 464,489	$ 489,343	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,902,898	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 4,902,898	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 464,489	$ 5,392,241	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,312,309	$ #REF!	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,776,798	$ #REF!	48

*(See instructions.)

Facility Name & ID Number BRYN MAWR CARE, INC. **#** 0035618 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF OTHER ASSETS & LIABILITIES **As of** 12/31/00

OTHER CURRENT ASSETS:	Amount	Amount
Real Estate Tax Escrow	54,839	54,839
	54,839	54,839
OTHER NON CURRENT ASSETS:		
Capital Reserve Escrow	3,625	3,625
Refinancing Fees - Net		60,901
	3,625	64,526

OTHER CURRENT LIABILITIES:	Amount	Amount
Due To IDPA - Audit	102,611	102,611
	102,611	102,611
OTHER NON CURRENT LIABILITIES:		

Facility Name & ID Number BRYN MAWR CARE, INC. # 0035618 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,247,780	1
2	Restatements (describe):		2
3	Schedule attached		3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,247,780	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,421,729	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(1,357,200)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 64,529	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,312,309	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number	BRYN MAWR CARE, INC.	#	0035618	Report Period Beginning:	01/01/00	Ending:	12/31/00

Balance per General Ledger		1,247,780
Adjustments:		
		-
		-
		-
Total adjustments		-
Balance - Beginning of Year		1,247,780
Equity(Deficit) from Page 17 Col 1		1,312,309
Related Party		
Equity(Deficit)	-3915988	
Income	89570	
		(3,826,418)
Combined Equity - End of Year		(2,514,109)

Facility Name & ID Number BRYN MAWR CARE, INC. # 0035618 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,092,608	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,092,608	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	49,588	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 49,588	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	7,124	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 7,124	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,149,320	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	718,273	31
32	Health Care	1,097,817	32
33	General Administration	1,046,691	33
	B. Capital Expense		
34	Ownership	769,284	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	95,526	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,727,591	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,421,729	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,421,729	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No Cash Basis If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number **BRYN MAWR CARE, INC.** **# 0035618** **Report Period Beginning:** **01/01/00** **Ending:** **12/31/00**

SUPPLEMENTAL SCHEDULE OF REVENUES
12/31/00

	DESCRIPTION	AMOUNT
1	Vending Commissions	1,300
2	Jury Duty	34
3	Copying	50
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
	TOTALS	1,384

Facility Name & ID Number BRYN MAWR CARE, INC. # 0035618 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,683	1,811	$ 43,662	$ 24.11	1
2	Assistant Director of Nursing	1,532	1,682	31,530	18.75	2
3	Registered Nurses	786	786	16,538	21.04	3
4	Licensed Practical Nurses	11,483	12,976	186,684	14.39	4
5	Nurse Aides & Orderlies	46,936	50,039	358,326	7.16	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,802	2,091	21,926	10.49	9
10	Activity Assistants	10,244	11,321	73,640	6.50	10
11	Social Service Workers	16,524	17,412	173,060	9.94	11
12	Dietician					12
13	Food Service Supervisor	1,762	1,995	25,741	12.90	13
14	Head Cook	4,531	4,777	35,660	7.46	14
15	Cook Helpers/Assistants	9,253	9,829	64,083	6.52	15
16	Dishwashers					16
17	Maintenance Workers	1,802	2,091	38,016	18.18	17
18	Housekeepers	14,909	15,850	97,853	6.17	18
19	Laundry					19
20	Administrator	1,986	2,211	75,788	34.28	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,550	8,600	96,373	11.21	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,808	4,107	53,054	12.92	31
32	Other Health Care(specify)					32
33	Other(specify)	0	0	0		33
34	TOTAL (lines 1 - 33)	136,591	147,578	$ 1,391,934 *	$ 9.43	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	16/MONTHLY	$ 845	1-3	35
36	Medical Director	MONTHLY	3,600	9-3	36
37	Medical Records Consultant	96	4,032	10-3	37
38	Nurse Consultant	MONTHLY	34,452	10-3	38
39	Pharmacist Consultant	MONTHLY	1,440	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	45	2,092	11-3	44
45	Social Service Consultant				45
46	Other(specify) Specialized Rehab		15,456	10A-3	46
47	DIR FOOD SERVICE		17,748	1-3	47
48	Dietary Consultant- SIR MGT	MONTHLY	12,000	1-3	48
49	TOTAL (lines 35 - 48)	141	$ 91,665		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,202	$ 37,092	10-3	50
51	Licensed Practical Nurses				51
52	Nurse Aides	1,052	17,497	10-3	52
53	TOTAL (lines 50 - 52)	2,254	$ 54,589		53

Facility Name & ID Number BRYN MAWR CARE, INC. # 0035618 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS

B. CONSULTANT SERVICES

# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
		$	$
0	0	$ 0	$ #DIV/0!

Facility Name & ID Number BRYN MAWR CARE, INC. # 0035618 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
MARTIN LEE	ADMINISTRATOR	0	$ 43,510
DATES OF SERVICE 6/27/00 - 12/31/00			
AUGUSTO BELEY	ADMINISTRATOR	0	32,278
DATES OF SERVICE 1/1/00 - 6/26/00			
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 75,788

B. Administrative - Other

Description	Amount
Arthur Roseau-Director Fee	$ 125
Management Fees - See Attatched	291,138
Management Service Fees - See attatched	61,068
TOTAL (agree to Schedule V, line 17, col. 3)	$ 352,331
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
See Attatched Schedule	Legal Fees	42,140
Preferred Bookkeeping	Accounting	20,500
Frost, Ruttenberg & Rothblatt	Accounting	11,435
Preferred Bookkeeping	Computer Services	4,176
Personnel Planners	Unemployment Consulting	1,130
Preferred Bookkeeping	Bookkeeping Services	52,200
SIR Management	Regulatory Services	14,100
Mid America Programing	MDS Software	1,320
Property Valuation Services	Appraisal	2,500
Amari & Locano	RE Tax Protest	2,033
Unlimited Technology Inc	Computer Services	210
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 151,744

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 5,655
Unemployment Compensation Insurance	21,028
FICA Taxes	104,803
Employee Health Insurance	41,208
Employee Meals	12,938
Illinois Municipal Retirement Fund (IMRF)*	
UNION HEALTH AND WELFARE	33,803
EMPLOYEE BENEFITS	7,052
Chicago Head Tax	3,676
TOTAL (agree to Schedule V, line 22, col.8)	$ 230,163

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	11,089
Health Care Worker Background Check	
(Indicate # of checks performed 135)	807
Inspections, Licenses, Fees	2,283
Advertising and Promotion	2,203
Illinois Council on LTC	5,568
Alloc - ECM Owners Council	59
Alloc - Prefferred Bkpg.	303
Alloc - SIR Management	960
Less: Public Relations Expense	( )
Non-allowable advertising	(2,203)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 21,269

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,702
Alloc - Prefferred Bkpg	154
Alloc - SIR Management	520
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,376

**See instructions.

Facility Name & ID Number BRYN MAWR CARE, INC. # 0035618 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number BRYN MAWR CARE, INC. # 0035618 Report Period Beginning: 01/01/00 Ending: 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL ON LTC $5,829**

(3) Did the nursing home make political contributions or payments to a politica action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period?

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **1,200** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen of Public Aid during this cost report period. $ **95,526**
This amount is to be recorded on line 42 of Schedule V

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classifiec in the Ancillary Section of Schedule V? **NA**

(14) Is a portion of the building used for any function other than long term care services fo the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. $ **12,938** Has any meal income been offset against related costs? **NO** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **NONE**
d. Have vehicle usage logs been maintained? **NA**
e. Are all vehicles stored at the nursing home during the night and all othe times when not in use? **NA**
f. Has the cost for commuting or other personal use of autos been adjustec out of the cost report? **NA**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of service performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

Date: **07/17/2000**

To: **Administrator/Cost Report Preparer**

From: **Office of Health Finance**

Re: 2000 Long Term Care Cost Report and Instructions on Diskette
Information Regarding the Lotus 5.0 and Excel 97 Versions of the Cost Report

Enclosed you will find a copy of the 2000 cost report and instructions on diskette. For 1999, the majority of nursing homes used the diskette to prepare their cost report. We would appreciate it if you could complete your 2000 cost report using this diskette.

If you choose not to use the diskette, you may print the 2000 cost report form and manually complete the report. If you do not have the ability to print the cost report form and instructions, please contact our office at 217/782-1630 to request a paper copy to be mailed to you.

As is stated on page 1 of the cost report instructions, this report should cover the facility's fiscal year ending in 2000. It is due on September 30, 2000, or ninety days after the close of the facility's fiscal year, **whichever comes later**. Please refer to the instructions for the remainder of the filing requirements.

There are two 2000 cost report files on the disk you have received. One file has been created for use with Lotus 5.0 for Windows. The other file has been created for use with Excel 97. A copy of the 2000 cost report instructions has been included on the diskette also. The name of the file is Instr00. It has been created for use with Word Perfect 6.1. Please use this 2000 diskette. **Printed copies of the report from the 1999 cost report diskette or earlier diskettes will NOT be accepted.**

Each page is on a separate worksheet. The file has been sealed. The cells where data is to b entered have been unprotected. Do not change the cost report form. We must have every form the same. Any changes made to the cost report form will cause us to consider the filed cost report incomplete until the form is correctly filed. Complete page one first. The facility name, IDPH ID# and the report period dates have been linked to each page. (Be sure to enter the IDPH licensed name of the facility.) **When entering data on pages 3 and 4, do not include decimals. Please round to whole numbers. When entering the years on page 12 do not enter various or other text in columns 2 or 3.**

Print macros have been written that will print each individual page or the entire report.

WARNING: Do NOT use drag & drop, cut or move commands. These commands may ruin the file and/or formulas. Then you will have to close the file and start from the last time you saved it.

As you know, save your work frequently to prevent losses of large amounts of information.

The cost report must be printed on 8 ½ by 14 size white paper with an 8 ½ by 14 image on the paper. To ensure an 8 ½ by 14 size image, check the paper size in the Printer Setup. When printing the cost report, be sure the "Selected Range" is checked. If "Current Worksheet" or "A Worksheets" are selected, the printed report will be smaller than it should be. These three selections appear in the Print dialog box. **Please do not reduce the image to 8 ½ by 11. We cannot accept a report with an 8 ½ by 11 image.** After printing the cost report, please review the copy for accuracy and completeness before mailing it to The Office of Health Finance. **Please send in the completed diskette with your paper copy, (being sure to make a copy of the diskette for your records).** Also, please make sure both the completed diskette and the paper copy agree prior to sending to our office.

Notes Applicable only to Lotus users

The entire cost report is in one file named Report00.wk4. A print preview button has been added to the bottom of each page. You may want to preview each page to ensure there are no problems before you print the entire cost report. To preview a page, click this button, then click File-Preview as normal. Also, macros have been written that will allow you to change the column width or row height of a cell or range of cells. **Only use these commands on the extra pages (24 through 33).** The print menu or the other macros menu will appear on the menu ba after you click the macro button. A macro that allows you to "Freeze Both Titles" has been added also. This will be helpful for data entry. **When saving the file in Lotus, please save it as a "WK4" file type instead of a "123" file type. To do this, click File-Save As, and then ensure the file type is "WK4".**

To copy worksheets that you have created into the blank pages at the end of the report, use Fi Combine. This will bring in the styles you used in your worksheet (except for the column width and the row height). This does not work if you are using Lotus 97. Extra sheets for pages 6, 8 and 12 have been included in the file. Click the macro buttons on these pages to make them available.

Notes Applicable only to Excel users

The entire cost report is in one file named Report00.xls. In an Excel 97 file that has been seale you can press the Tab key to go to the next unprotected cell. By pressing Shift-Tab, you can g to the previous unprotected cell. Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available. Also there are some blank unprotected sheets after "Page 23".

If you have any questions concerning the diskette, please call Randy Hulskotter at (217) 782-1630.

RH/cw